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ABSTRACT

The paper discusses specific concerns and issues related to the assessment of profoundly deaf clients. Data on 11 profoundly deaf clients are used to illustrate the problems involved in assessment, and practical strategies for assessment are presented. One case study is detailed. The importance of assessing functional communication skills is stressed. The use of a checklist of communication skills, assessment of interpreter reliability, and use of both hearing American Sign Language interpreters and deaf reverse skills interpreters are suggested. Other useful evaluation measures are noted, including the Test of Communication Skill, assessment of vocalization using traditional techniques of speech pathologists, intelligence tests, the Woodcock Reading Mastery Tests, and the KeyMath Diagnostic Arithmetic Test. The rigid use of formalized normative tests is deemed to be inappropriate in cases involving severely socially deprived deaf adults. (Author/DB)

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Assessment and Rehabilitation of Severely Socially Deprived Deaf Adults

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Abstract

The paper discusses specific concerns and issues related to the assessment of profoundly deaf clients. Data on 11 profoundly deaf clients are used to illustrate the problems involved in assessment, and practical strategies for assessment are presented.

This paper reports data on 11 profoundly deaf clients who present special problems for both assessment and rehabilitation. They are clients who have been described by Judge Alan T. Cooke of the Court of Queen's Bench in Alberta as not communicating in sign language or other known "gestural" communication, suffering from severe social deprivation, and incapable in Court (or elsewhere) of understanding proceedings or processes which have a direct effect on their emotional, social, and psychological well-being (Regina vs. Shupe, 1987). Interestingly, the same judgement makes a plea for the provision of appropriate rehabilitative services, and it is the lack of these services and of adequate assessment techniques which precipitated our involvement as a university clinic.

Little research has addressed the assessment and rehabilitation of these clients. However, much of the work that has been done in the area of psycho-educational assessment, both prior to and as a result of legislation such as Public Law 94-142 in the United States and Bill 82 in Ontario, is relevant. The legal requirement for nondiscriminatory, multidisciplinary testing conducted in the child's native language or mode of communication has focused interest on the holistic types of assessment and rehabilitation or program planning which we also advocate.

Sources such as *Nondiscriminatory Multifactored Assessment* (Barnett, 1983) and *Low Incidence Children: A Guide to Psyhocoeducational Assessment* (Ray, O'Neill, & Morris, 1983) provide an introduction to many of the issues involved in placement of these exceptional needs individuals. Specifically addressing concerns dealing with hearing im-

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paired individuals, *Hearing-Impaired Children & Youth with Developmental Disabilities: An Interdisciplinary Foundation for Service.* (American Speech-Language-Hearing Association, 1985, edited by Cherow) is another recommended source.

The Clients

Each of the clients who form the focus of this paper had one or all of four characteristics. They were, or were thought to be, deaf. They were unable to communicate effectively even with those skilled at communicating with deaf students or adults. They were regarded as "unteachable" and/or had been erroneously assessed in the past. They were unable to benefit from or had been excluded from previous placements or rehabilitative services but were in considerable need of such services. At one extreme was the client who was "living rough" and eating out of garbage cans; at the other extreme was a client who held a minimally skilled job as a dishwasher and had a supportive family, but had been charged with a major offence by the police.

Six of the clients were male, five were female. Two were less than 20 years of age, four were 21 to 25 years, and five were over 40 years of age. Eight of the clients had either no expressive/receptive communication skills or only very basic gestural/American Sign Language (ASL) skills; the other three had rudimentary English/lip reading skills. In nine cases, there were major questions about placement, guardianship, or antisocial behavior; in two others, the questions were concerned with vocational guidance or remediation. Three clients were referred by the public guardian, two by the court, five by social service agencies and one by the court and the public guardian. One client was not deaf; one was classified as "central deafness." A brief synopsis of the case of L.R. will serve to illustrate a typical client seen in our clinic.

> L.R. was the fourth of eight children in a family characterized as experiencing serious social, economic, and health problems. Six of the eight children and the mother were reported to be functioning at a low intellectual level. L.R. and a younger brother, also deaf, attended a school for the deaf in Western Canada as day students. For some time after leaving this school (at the age of eighteen), there is little information recorded concerning placement or rehabilitative services. At about the age of 31 years, records are again available and refer to behaviors which indicate L.R. was "living rough," that is, eating from garbage cans, sleeping wherever possible, and similar asocial behavior. From 31 years to 40 years of age L.R. was living in a residential home for mentally handicapped adults and then in a group home for deaf adults.
>
> L.R. was referred to our clinic in preparation for an upcoming court appearance. He had been charged with assault following an incident involving touching and pestering a woman. She was previously unknown to him. The behaviors which brought about these charges were not an isolated incident. Criminal charges, however, had not been laid in previous instances. An assessment of L.R.'s ability

to understand the charges pending against him and an indication of the potential for improving his communication skills were requested. Also required were recommendations regarding appropriate placement and remediation.

A careful review of previous assessment history provided some information regarding this case. Notations of "mentally handicapped" and "mild mental retardation" were seen in reports along with descriptions of behavioral and social difficulties.

The assessment team consisted of a certified psychologist with specialization in exceptionalities and individualized intelligence testing, a sessional instructor with specialization in oral communication, an educational consultant with specialization in auditory functioning, and a certified psychologist and professor of Educational Psychology. Certified interpreters and a reverse-skills interpreter worked with the team.

L.R. was unable to read and able to write only a few words. Sign vocabulary was limited to approximately 25 concrete concepts. Many behaviors were associated with a pattern similar to those shown by a client with a long history of institutionalization. Touching, putting his arm around women, and similar related actions are a form of behavior reinforced by institutional handling. There was nothing to suggest that they had a sexual intent.

Using a wide variety of standardized and nonstandardized measures and techniques, L.R. was found to be of normal or above normal nonverbal intelligence, but he exhibited major developmental deficiencies. Inadequacies of educational and vocational experiences were seen as a probable explanation. This conclusion was based on the results of both formal and informal assessment procedures, clinical experience, and clinical judgement.

Our conclusions and recommendations specifically stated that L.R. would not be able to understand legal proceedings or communicate adequately about legal matters. Understanding of moral concepts was limited not by innate ability but by educational and social history. As a result, he would have little understanding of the consequences of his actions unless this was systematically communicated to him through a carefully developed and properly implemented program of behavioral change. Recommendations for such a supportive program, in his present group home, were made.

Criminal charges were eventually stayed in the case of L.R. Though beneficial to L.R. in some respects, such an outcome removes the possibility of court-ordered rehabilitative services. It means that the provision of ongoing support and rehabilitation will be that much more difficult in the future.

Assessment

A full assessment of clients such as L.R. is difficult, time consuming, and unless well done, can be highly misleading. In our clinic, a full bat-

tery includes an assessment of (a) functional communication skills; (b) a specific assessment of manual communication skills including ASL, Pidgin Signed English (PSE), finger spelling, and Manually Coded English (MCE); (c) an assessment of receptive English language skills with manual English cueing, auditory cueing, and/or lip reading cueing; (d) an assessment of expressive English language skills using vocalization; and (e) a general psychological assessment of cognitive, academic (reading, math, writing), and psychosocial/behavioral skills. In all assessments, clinical observation is a vital and major component, and to date no client has had sufficient speech to allow for assessment of spoken English skills. All the clients have minimal reading and writing skills.

Functional Communication Skills

The evaluation of functional communication skills, usually of a sign/gestural type, is perhaps the most innovative area of our clinical practice. There are three main components to this evaluation.

First, a checklist of functional communication skills is used to assess the pragmatic aspects of communication (Correia & Sobsey, 1984). Second, we may use techniques developed by Richard Sobsey and Marlene Spencer to assess "interpreter" reliability. We find that in many cases, contextual cueing allows caretakers who act as interpreters, to make assumptions about communication which are not warranted. For example, the understanding of "eye point" with a Bliss Symbol board can be seriously biased if the interpreter knows the questions being asked of the client. In some extreme cases, we find that in the absence of auditory cueing, the interpreter's performance is no greater than would be predicted by chance. *Such a finding invalidates much if not all of the previous diagnostic information on the client.*

Third, we use both hearing ASL interpreters and reverse skills interpreters to assess functional aspects of communication. A reverse skills interpreter is a deaf person with special skills in communicating with other deaf people and with a formal knowledge of both ASL and English. The focus of the evaluation is on the semantic and syntactical content of the client's communication system and on the underlying conceptual system. We find in many cases, that the clients have a developed, even highly developed, conceptual system but a very idiosyncratic and personal communication system.

Other Tests

Other tests that we have found useful in assessing these clients are the Test of Communication Skill (Grove, O'Sullivan, & Rodda, 1979) and assessment of vocalization using the traditional techniques of the speech pathologist. When used appropriately, good tests for intelligence

are the Wechsler Adult Intelligence Scale—Revised (Wechsler, 1976), the revised Standford-Binet (Thorndike, Hagen, & Sattler, 1986), the new British Aptitude Scale (Elliot, Murray, & Pearson, 1983), and the progressive Matrices—Revised (Raven, 1977). For reading, we usually use the Woodcock Reading Mastery Tests (Woodcock, 1973), and for Math we usually use KeyMath Diagnostic Arithmetic Test—Canadian Edition (Connolly, Machtman, & Pritchett, 1979). For writing, we use the Test of Communication Skills for an analysis of overall abilities and specific techniques.

It should be emphasized that in all cases the rigid use of any formalized normative test is inappropriate. Norms based on general population statistics, or even those based on populations with specific identifiable handicapping conditions, may not be appropriately used for comparison with the severely socially deprived deaf adult. History, present abilities, communication, and behavioral differences will combine to make such comparisons unhelpful at the very least and can often be detrimental to the best interests of the client. Such comparisons may tend to present an unclear overall impression of the client's personal strengths and weaknesses, and clinical experience is a vital prerequisite to their use. We often have to violate the procedures for test administration. Communication difficulties and unusual behaviors may make it impossible to follow standard administrations. For example, the use of a reverse skills interpreter, which may be necessary to evoke the most meaningful responses, invalidates assumptions of standard administration and the subsequent normative comparisons. Idiosyncratic behaviors and communications cannot be truly assessed for functional adaptation without careful observation and clinical judgement. The combined experience of the team serves to ensure that practical assessment skills and judgement are interdependently utilized with test or assessment batteries. If these conditions are not met, tests of this type can be highly misleading.

Conclusions

As long ago as 1966, Denmark identified a serious problem of misdiagnosis of some profoundly deaf individuals (Denmark, 1966). The problem continues, and all of the clients referred to in this report have a history of misdiagnosis and placement in inappropriate institutions or rehabilitation facilities. Unfortunately, the problem is only usually identified when a crisis occurs, either of a familial or social nature. Such problems arose even in the case of the six of the 11 clients whose "only disability" was deafness. The problem is essentially one of inadequate early education, lack of appropriate support systems for clients and their families, and a lack of qualified teachers, social workers, and interpreters.

Assessment should only be undertaken by an experienced and qualified team. Interestingly, when this is done, prognosis is much better than is generally predicted, provided an intensive and supportive rehabilitation program is available. It is the lack of such programs that is the primary obstacle preventing longer term solutions, and as Justice Alan T. Cooke says:

> I am aware that a stay of proceedings in this case creates a third status somewhere between unfitness to stand trial by reason of insanity and fitness to stand trial and thereby subject to the sanctions of the law. Cases such as this will face the criminal justice system with such frequency that Parliament, in my view, should address the problem. (Regina vs. Shupe, 1987).

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